HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00051/1

TITLE: The Vermont Health Access Plan

AWARDEE: Vermont Agency of Human Services

TABLE OF CONTENTS

I. PREFACE

The following are terms and conditions for the award of the Vermont Health Access Plan (VHAP) demonstration waiver request. The terms and conditions have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/ Operational Plan.

In addition, specific requirements are attached, entitled: Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A); General Administrative Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring of Budget Neutrality (Attachment D); Access Standards (Attachment E); Outline for Operational Protocol (Attachment F); and Recommended Minimum Data Set (Attachment G).

Note: DDMHS refers to the Vermont Department of Developmental and Mental Health Services, which is a prepaid health plan (PHP) as defined in 42 CFR 434.2.

II. GENERAL CONDITIONS

1. All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation. No Federal Financial Participation (FFP) will be provided for marketing, enrollment or implementation until HCFA has approved these requirements. FFP will be available for project development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain HCFA approval of a submission, HCFA will make every effort to respond to the submission in writing within 30 days of receipt of the submission. HCFA and the State will make every effort to ensure that each submission is approved within sixty days from the date of HCFA's receipt of the original submission.

*2. Within 60 days of award, the State will submit a pre-implementation workplan for approval by the HCFA project officer. The workplan will specify timeframes for major tasks and related subtasks for managed care expansion.

*3. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA during the course of the waiver negotiation and approval process. The protocol must be submitted to the HCFA project officer no later than 70 days prior to the implementation date of the program (implementation defined as the first date when beneficiaries select a health plan). HCFA will respond within 30 days of receipt of the protocol regarding any issues or areas it believes require clarification. HCFA and the State will make every effort to ensure that the protocol is approved within 60 days from the date of its original submission. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 60 days prior to the date of implementation of the change(s) for approval by HCFA. The Special Terms and Conditions and Attachments include requirements which should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol. Where not specified in the protocol, the State's original waiver proposal, as modified or clarified in written responses to HCFA questions, shall govern.

4. a. The State will submit a phase-out plan of the demonstration to HCFA six months prior to initiating normal phase-out activities and, if

desired by the State, an extension plan on a timely basis to prevent disenrollment of VHAP members if the waiver is extended by HCFA. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to HCFA review and approval.

b. During the last 6 months of the demonstration, eligibility determination of individuals who would not be eligible for Medicaid under the current State plan will not be permitted unless the waiver is extended by HCFA.

5. HCFA may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge HCFA's finding that the State materially failed to comply. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.

6. The State will comply with:

   a. Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A)
   b. General Administrative Requirements (Attachment B)
   c. General Reporting Requirements (Attachment C)
   d. Monitoring of Budget Neutrality (Attachment D)
   e. Access Standards (Attachment E)
   f. Outline for Operational Protocol (Attachment F)

III. LEGISLATION

1. a. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to VHAP. To the extent the enforcement of such laws through regulations and official policy statements issued by a Bureau director and/or Associate Regional Administrator or higher would have affected State spending in the absence of the

demonstration in ways not explicitly anticipated in this agreement, HCFA shall incorporate such effects into a modified budget limit for VHAP. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. HCFA will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this special term and condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the VHAP demonstration (e.g., all disallowances involving provider taxes or donations), and if HCFA and the State working in good faith to ensure State flexibility in deciding where the appropriate modifications should occur, do not agree within 90 days to establish an alternative methodology for revising the without waiver baseline, the effect of enforcement on the State's budget limit shall be proportional to the size of the VHAP demonstration in comparison to its entire Medicaid program (as measured in aggregate medical assistance payments).

b. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after July 31, 1995. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, HCFA shall incorporate such changes into a modified budget limit for VHAP. The modified budget limit would be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the VHAP demonstration (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to HCFA for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Vermont, HCFA would approve the methodology. Should HCFA and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-waiver States.

c. The State may submit to HCFA an amendment to the program to request exemption from changes in law occurring after July 31, 1995. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the modified VHAP program

do not exceed projected expenditures in the absence of VHAP (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/ OPERATIONAL PLAN

A. Eligibility Review

1. The State will continue to maintain a Medicaid Eligibility Quality Control (MEQC) program for traditional eligibles. The expanded eligibility group shall be incorporated into the Income Eligibility Verification System (IEVS), which verifies income. This data combined with other information shall be used to implement control mechanisms. Control mechanisms to be implemented shall be included in the protocol.

2. The State will cooperate with HCFA in its monitoring activities related to the accuracy of coding cases as (1) eligible under previous Medicaid criteria or (2) eligible only under VHAP criteria.

B. Capitation Rates

1. The State will submit to HCFA for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the Managed Care Plans (MCPs) and DDMHS throughout the demonstration. Also, the State will submit the methodology for determining the fee-for-service upper payment limits for services.

C. Managed Care Plan Contracting

1. The State will use a Request for Proposal (RFP) process to select contracting MCPs. This process will be open to all MCPs that meet VHAP participation standards, including minority-owned plans.

2. Before issuing the solicitation for MCPs, the State shall submit the RFP for review by the HCFA project officer. HCFA will have 21 days to provide comments to the State.

3. The State shall submit to HCFA, for its review and comment, the RFP for the Benefits Counseling Contractor at least 21 days prior to its issuance.

4. The State will provide HCFA with 30 days to review and approve the executed contract prior to its use. No FFP will be available for contracts using a contract which has not been approved by HCFA in advance of the effective dates of the contracts.

D. Managed Care Plan and DDMHS Contracting

1. a. The State will notify the HCFA project officer of significant changes to any provider network which affect access and quality of care, and the State shall define within its protocol contingency plans for assuring continued access to care for enrollees in the case of an MCP or PHP-DDMHS contract termination and/or insolvency, or in case of significant disruptions in the provider network for the CRT Program.

b. HCFA reserves the right to review and approve individual subcontracts with MCPs or with DDMHS in accordance with the same requirements as those imposed by these Special Terms and Conditions on MCPs and DDMHS. Copies of subcontracts or individual provider agreements with managed care organizations or DDMHS shall be provided to HCFA upon request.

c. The State shall establish a process by which it receives, reviews, and approves all marketing materials prior to their use by health plans or by DDMHS.

d. In the protocol, the State shall describe how homeless populations will access health care services under the demonstration. The protocol will include a description of how providers of care to this population will be incorporated in the managed care model and reimbursed for their services to this population.

2. a. The State must provide the methodology it will use to determine whether each MCP and DDMHS has an adequate provider network in relation to the geographic location of Medicaid beneficiaries. For MCPs, this methodology will be incorporated under the plan evaluation and selection process.

b. The State must provide the methodology it is using to determine whether each region in the State (as defined by the State) has sufficient MCP provider capacity to justify mandatory managed care enrollment. This should consider both the incidence of providers enrolled with multiple MCPs and the percentage of provider caseloads open to Medicaid clients in relation to the geographic location of Medicaid beneficiaries.

c. The State must provide the HCFA Regional Office (RO) with an annually updated listing of all providers (primary and specialty) participating in the demonstration.

d. In the protocol, the State will provide assurances to HCFA that the fee-for-service system is being maintained in areas where provider capacity is determined to be insufficient.

*3. The State must meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with MCPs prior to the start date of the demonstration, and for contracting with DDMHS prior to the start date of the CRT Program. Such requirements include disclosure of ownership and completion of the standard HCFA disclosure form.

E. Family Planning

*1. In the protocol, the State should provide HCFA with a description of available family planning services and assurances that access to these services is not restricted by the VHAP demonstration.

2. The State will provide HCFA with any amendments to the Title X provider agreements which occur as a result of the demonstration.

F. Federally Qualified Health Centers (FQHCs)

1. a. For FQHCs that are established prior to the start date of the demonstration, the State will assure (except as specified in 1b below) that health plans within the FQHC's service area contract with the FQHCs. If an FQHC forms its own MCP, health plans will not have to contract with the FQHC.

b. For any health plan that requests relief from the requirement, the State shall submit to HCFA a report with the following information at least 30 days prior to submission of the final HMO contract for the RO approval:

1) The FQHCs in the health plan's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2) An analysis that the health plan has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the MCP, capacity of each provider to take on additional Medicaid patients, geographic location of providers, and description of accessibility for Medicaid patients to

these providers. The health plan must inform the State if any of this information or data changes over the course of the demonstration.

3) An analysis that the health plan will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State plan and actually provided by the FQHC under the fee-for-service program), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients.

2. For FQHCs/RHCs which are established prior to the start date of the demonstration, the State will use, over the term of the demonstration, a year-end reconciliation process to assess revenues received through payment from the plans compared to reasonable allowable costs; if revenues are below 100 percent of reasonable allowed costs, the State will reimburse those FQHCs/RHCs the difference. FQHCs/RHCs may elect to permanently waive the cost reconciliation process for the duration of the waiver.

3. FQHCs/RHCs which are established after the start date of the demonstration will not be entitled to retroactive Medicaid cost reimbursement, unless it is determined by the appropriate State entities, with the advice of health plans, that this reimbursement is necessary to provide primary care access for enrollees in the geographic area served by the practice. If cost based reimbursement is used, it will be limited to the mean cost for FQHCs or free standing RHCs.

G. Encounter Data Requirements

1. a. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The recommended minimum data set is attached. The State must perform periodic reviews, including validation studies, in order to ensure compliance, and shall have provisions in its contract with the managed care organizations and with DDMHS to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The State shall submit the proposed minimum data set and a workplan showing how collection of plan encounter data will be implemented and monitored, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into

program change on a timely basis. If the State fails to provide reasonably accurate and complete encounter data for any MCP or for DDMHS, it will be responsible for providing to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

b. The State, in collaboration with MCPs, DDMHS, and other appropriate parties, will develop a detailed plan, submitted to HCFA, for using encounter data to pursue health care quality improvement. At a minimum, the plan shall include: how the baseline for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur; and what penalties will be incurred if information is not provided.

c. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

childhood immunizations;
prenatal care and birth outcomes;
pediatric asthma;
serious and persistent mental illness; and
two additional clinical conditions to be determined by the State based upon the population(s) served.

d. The State shall conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. The State shall submit a plan for HCFA approval describing how it will validate the completeness and accuracy of the encounter data.

H. Quality Assurance Requirements

*1. In the protocol, the State shall provide its overall quality assurance monitoring plan for the managed care organizations and for DDMHS. The State shall develop quality audits to be conducted by the State and an external review agency to monitor the performance of the plans and DDMHS under VHAP. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan and DDMHS and its subcontractors. In the protocol, the State shall provide detailed criteria for monitoring the financial performance and quality assurance of each plan and DDMHS and its subcontractors. Upon request from HCFA, the State shall submit to the Center for Medicaid and State Operations (CMSO) and

the RO copies of all financial audits of participating managed care organizations and quality assessment reviews of these plans and DDMHS.

2. a. Within 15 months of implementation, the State shall conduct a survey of each managed care organization. The survey, which shall be described in the protocol, will measure satisfaction and, for MCPs, include: measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; the number and causes of disenrollments; and coordination with other health programs. The survey for DDMHS shall measure satisfaction, shall be described in the protocol, and shall be submitted to HCFA for approval 60 days prior to use. Results of the survey**s** must be provided to HCFA by the 18th month of project implementation. Thereafter, the State shall conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process. Such survey**s** shall be designed to produce statistically valid results.

   b. The State shall establish a quality improvement process for bringing managed care organizations, and DDMHS, which score below the State's benchmarks for specific and overall beneficiary satisfaction measures up to an acceptable level. The State will specify the benchmarks in the protocol.

3. Vermont shall collect and review quarterly reports on grievances received by each managed care organization and by DDMHS which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

4. Guidelines for State Monitoring of MCPs and DDMHS

   a. The State will require, by contract, that MCPs and DDMHS meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

   b. The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), MCP's and DDMHS adherence to these standards, through the following mechanisms: review of each plan's written QAP; review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes; and on-site monitoring of the implementation of the QAP standards.

5. Guidelines for MCP and DDMHS Monitoring of Providers
MCPs and DDMHS will require, by contract, that providers meet specified standards as required by the State contract. MCPs will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

6. MCPs will satisfy access and solvency requirements in 1903(m)(1)(A)(i)(ii); MCPs and DDMHS shall meet requirements in 1902(w).

I. Management Information Systems

*1. The State will develop a Detailed Implementation Schedule (DIS) addressing the State's approach to achieving changes, modifications and enhancements to its Medicaid Management Information System (MMIS), Eligibility System (ACCESS) and other systems capability to ensure the State's readiness to:

a. Collect, process, and maintain recipient eligibility information necessary to support recipient enrollment;

b. Collect, process, and maintain health plan and DDMHS information necessary to support plan and DDMHS enrollment;

c. Process and pay capitation fees and other required compensation to participating plans and DDMHS;

d. Collect, validate and use encounter data from participating plans and DDMHS.

The DIS should include the components set forth in State Medicaid Manual (SMM) section 11237.

*2. Prior to enrollment of beneficiaries, the State must submit evidence to the HCFA RO that a management information system is in place which meets the minimum standards of performance or the functional equivalent required of the State's current management information system.

J. Medicare Pharmacy Benefit

*1. The protocol must contain a complete description of how the pharmacy benefit for low income Medicare beneficiaries will operate. This discussion

should include but not be limited to the following: delivery system; quality management and cost containment activities; utilization review; and monitoring and fiscal tracking of the benefit. In addition, the protocol must contain a description of any coinsurance or cost-sharing requirements imposed on beneficiaries receiving the Medicare pharmacy benefit.

K. CRT Program Protocol and Fiscal Accountability

*1. The protocol must contain a complete description of how the CRT Program will operate, as well as revisions that reflect changes associated with the CRT Program. The description of the CRT Program and the revisions should include items required by these terms and conditions, and should include but not be limited to the following: eligibility; delivery system; payment mechanism; financial management; information systems; quality management and cost containment activities; utilization review; coordination of care with MCPs, including a description of the process for exchanging patient specific information while protecting the confidentiality of the patient; grievance and complaint process; and monitoring and fiscal tracking of the Program.

2. OVHA will monitor and ensure on an annual basis that DDMHS has provided the appropriate State match necessary to draw down the FMAP for title XIX services provided to persons eligible for the CRT Program through this demonstration. OVHA will certify that such matching funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

3. OVHA must ensure that DDMHS maintains separate fiscal accountability for Medicaid funding, including Federal share and State match, under the CRT Program, apart from behavioral health funds provided by State, county, and/or other Federal programs.

4. The contract between OVHA and DDMHS should specify the permissible use of any excess funds, including the requirement that excess funds may be used only for activities related to services provided to CRT Program enrollees eligible through this demonstration. The protocol will describe how OVHA will monitor the compliance of DDMHS with the contract.

Attachment A

Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. a. The State will report net expenditures in the same manner as is done under the current Medicaid program. The State shall provide quarterly expenditure reports using the form HCFA-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in VHAP under section 1115 authority. HCFA will provide Federal Financial Participation (FFP) only for allowable VHAP expenditures that do not exceed the pre-defined limits as specified in Attachment D.

   b. Vermont will report VHAP expenditures through the MBES, following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, VHAP expenditures will be differentiated from other Medicaid expenditures by identifying on forms HCFA-64.9 and/or 64.9p the demonstration project number assigned by HCFA. Because expenditures are reported on the HCFA-64 by date of payment, Vermont must also submit along with each HCFA-64 quarterly report a supplemental schedule that details services and reported waiver expenditures according to the waiver year in which the services were provided. The procedure related to under this reporting process must be approved by HCFA as part of the protocol referenced in Section II.3 of these Special Terms and Conditions.

   c. All claims for VHAP services provided during the demonstration period (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify VHAP waiver expenditures using the procedures addressed above.

   d. In addition to the form HCFA-64, the State shall provide to HCFA on an annual basis (related to the period for which the expenditure limit is established) the actual caseloads for each traditional and hypothetical Medicaid eligibility group (i.e., Aid to Needy Families and Children; Aged, Blind, and Disabled, Spend-Down/Medically Needy, 1902(r)(2), 1931(b)-

Full VHAP Benefit, CRT, and MH-Duals). This information should be provided to HCFA 90 days after the end of the year.

2. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Vermont Medicaid and VHAP expenditures on the quarterly form HCFA-37. The State must provide supplemental schedules that clearly distinguish between waiver expenditure estimates (by major component) and non-waiver Medicaid expenditure estimates. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

3. HCFA will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

   a. Administrative costs associated with the administration of VHAP.

   b. Net expenditures and prior period adjustments of the Medicaid program which are paid in accordance with the approved State plan. HCFA will provide FFP for medical assistance payments with dates of service prior to and during the operation of the section 1115 waiver.

   c. The State will certify State/local monies used as matching funds for VHAP purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

4. Guidelines for Financial Monitoring of Participating Providers

   a. The State shall provide to HCFA, upon request, copies of all financial statements filed by insurers and HMOs with the Vermont Department of Banking, Insurance and Securities.

   b. The State shall provide to HCFA, upon request, copies of any Department of Insurance documents related to their monitoring of the financial stability of insurers and HMOs.

c. The State shall provide to HCFA, upon request, copies of all audits conducted by the State under the Federal Single Audit Act.

Attachment B

General Administrative Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. Vermont will request modifications to the demonstration by submitting revisions to the protocol (see Special Term and Condition section II.3) for HCFA approval. These modifications will include significant changes in policy and procedures. The State shall not submit amendments to the approved State plan relating to the new eligibles.

2. Substantive changes to the demonstration design (i.e., employer buy-in program and participation of the Veterans Administration [VA]) will require submission of a formal amendment to the proposal and advance HCFA approval. The State will work with HCFA in amending the waiver application in the later stages of the demonstration program. However, with respect to the VA, the requirement of a formal amendment will not apply if the VA meets the terms of a participating health plan with respect to Medicaid-eligible veterans or becomes a participating provider within another health plan. HCFA must approve the payment methodology to VA facilities who participate in VHAP either as a participating plan or provider.

3. By April 1 of each year, the State will submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to HCFA's Boston Regional Office and to the HCFA Central Office address contained in section 2700.4 of the State Medicaid Manual. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions.

4. All contracts and subcontracts for services related to the VHAP must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and (2) inspect and audit any financial records of such contractor/subcontractors. This includes contracts with MCPs, Third Party Administrators (TPAs), and DDMHS.

*5. Vermont must implement procedures so that hospitals will be able to distinguish individuals who would be eligible for Medicaid in the absence of the demonstration from all other individuals. These procedures must be in place and operational on the implementation date of the waiver so that hospitals can calculate traditional Medicaid days throughout the life of the waiver. Correct accounting for Medicaid days is required for calculating a hospital's Medicare disproportionate share hospital (DSH) payments. The proposed procedure must be submitted to HCFA in the protocol.

Attachment C

General Reporting Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. a. Through the first six months after implementation, including implementation of the CRT Program, the State will report on its progress in a series of monthly conference calls with the HCFA project officer, and will develop a detailed agenda prior to each call. Subsequently, the State will submit quarterly progress reports (including grievances), which are due 60 days after the end of each quarter.

   b. The reports should include a brief narrative of events occurring during the quarter that will affect access to health care, enrollment, quality of care (including statistics on grievances), MCP financial viability or other key operational areas. The report should include a separate discussion of State efforts related to the collection and verification of encounter data and provide summary utilization statistics (beginning in the third quarter). The report should also include proposals for addressing any significant problem areas.

2. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from the Center for Medicaid and State Operations (CMSO), a final annual report will be submitted.

3. At the end of the demonstration, a draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, ORD's Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

4. The State shall submit a continuation application by May 31 of each year (beginning in 1996).

Attachment D

Monitoring Budget Neutrality for the Vermont Health Access Plan (VHAP)

The following describes the method by which budget neutrality will be assured under the VHAP demonstration. Vermont will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, Vermont will be at risk for the per capita cost (as determined by the method described below) for current eligibles, but not at risk for the number of current eligibles. By providing FFP for all current eligibles, HCFA will not place Vermont at risk for changing economic conditions. However, by placing Vermont at risk for the per capita costs of current eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year, on a Federal fiscal year (FFY) basis. These annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year waiver period (January 1, 1996, through December 31, 2000) for the types of Medicaid expenditures described below. For each FFY, the Federal share will be calculated using the FMAP rate for that year.

Each yearly budget estimate will be the sum of separate cost projections for each of seven Medicaid enrollment groups (MEG) of beneficiaries and for Disproportionate Share Hospital (DSH) expenditures. The enrollee groups are (A) Aid to Needy Families and Children (ANFC); (B) Aged, Blind, and Disabled (ABD); © Spend-Down/Medically Needy (S-D); (D) 1902(r)(2) Children (1902); (E) 1931(b)-Full VHAP Benefit; (F) CRT; and (G) Mental Health -- Dual Eligibles (MH-Duals). The yearly cost projection for each MEG will be the product of the projected per capita cost for that MEG, times the actual number of enrollee/months in that group, as reported to HCFA by the State under Attachment A, Special Term and Condition #1(d), including eligibles counted as categorical, where the method for counting eligibles, including any factoring of the duration of eligibility, is consistent with the counting method used in the calculation of base year per capita costs and VHAP capitation payments.

Projected Per Capita Cost The State shall submit to HCFA a base year per capita cost for each MEG, subject to the approval of the project officer. These should reflect all expenditures related to services performed during State fiscal year (SFY) 1994 (i.e., expenditures should be totaled on a date of service basis) in the enrollee groups, except for: (1) the 1902 MEG; (2) the 1931(b)-Full VHAP Benefit MEG; (3) the CRT MEG; and (4) the MH-Duals MEG. The base year cost for the 1902 group is $39.63, which is the PMPM cost of under-insured Dr. Dynasaur children from SFY 1997. The base year cost for the 1931(b) group is $152.59, which is the SFY 1997 PMPM cost for VHAP expansion adults who are parents or caretaker relatives of Medicaid-eligible children, and who receive the full VHAP benefit.

The base year cost estimate for the 1902 group is estimated from actual experience for children eligible during 1997, since claims experience does not exist for the 225-300% FPL expansion group. The baseline will be adjusted to reflect actual experience if expenditures for the 225-300% 1902(r)(2) eligibles in their first year of demonstration eligibility are more than 10 percent above or below the trended baseline for that time period.

The reporting period for 1931(b) adults with family income up to 150% of the FPL begins on October 1, 1997. The reporting period for 1931(b) adults with family income between 150 and 185% of the FPL begins on March 1, 1999.

The base year cost for the CRT group is the PMPM cost for CRT services for traditional Medicaid eligibles (i.e., ANFC, ABD, S-D, 1931(b), eligibles with Medicare, eligibles with commercial insurance). The base year cost for the MH-Duals group is the PMPM cost for psychiatrist, psychologist, outpatient hospital psychiatric, and inpatient hospital psychiatric services for traditional Medicaid eligibles with Medicare or with commercial insurance, who were previously excluded from the demonstration. Upper limits for the base year PMPM for the CRT MEG and the base year PMPM for the MH-Duals MEG amendment will be calculated according to the following formula:

$$\frac{\text{Expenditures 4/1/98 through 2/28/99}}{\text{Member months 4/1/98 through 2/28/99}} \times (11/12) + \frac{\text{Expenditures 1/1/99 through 2/28/99}}{\text{Member months 1/1/99 through 2/28/99}} \times (1/12)$$

Vermont will submit expenditure and member month data for the period April 1, 1998 through March 31, 1999 by November 1, 1999. The base year PMPM for the CRT MEG will be the lower of upper limit PMPM for the CRT MEG and the PMPM for the CRT MEG calculated using data for the entire period. The base year PMPM for the MH-Duals MEG will be the lower of upper limit PMPM for the MH-Duals MEG and the PMPM for the MH-Duals MEG calculated using data for the entire period.

Per capita costs for all MEGs for SFY 1995 and beyond will be derived by inflating the base year per capita costs, using the rates of increase listed below.

Per Capita Growth Rates for the Vermont Health Access Plan

SFY	ANFC	ABD	S-D	1902	1931(b)	CRT	MH-Duals
1995	9.53%	10.70%	21.60%				
1996	19.95%*	14.50%*	24.51%				
1997	8.02%	10.70%	13.19%				
1998	6.51%	10.70%	4.78%	6.51%	4.77%		
1999	6.51%	5.86%	4.78%	6.51%	4.77%	3.27%	3.27%
2000	6.51%	5.86%	4.78%	6.51%	4.77%	3.27%	3.27%
2001**	6.51%	5.86%	4.78%	6.51%	4.77%	3.27%	3.27%

Footnote: * The rates of increase for SFY 1996 include the Medicaid physician and dental fee increases enacted by the State in April 1995.

** The six month period from July 1, 2000 through December 31, 2000, will be trended at the same rate as SFY 2000 in order to continue budget neutrality through year five of the demonstration.

Projected DSH Expenditures The projected yearly DSH expenditures for the demonstration will be calculated using a base year figure grown at a predetermined growth rate. The base for DSH will be the lower of the State's total DSH expenditures for FFY 1995 or $29,081,000, which is the State's final allotment for FFY 1995. The base amount will be grown up to and during the waiver at 6.94 percent annually. However, after October 1, 1997, the Federal share of the trended amount will be limited to the lower of either the trended amount or the State's DSH allotment.

Sample Calculation Suppose the base year per capita cost for the ABD MEG is $381.77. Using the rates of increase in the above table, the projected per capita cost for this category in SFY 1997 is $535.68. Suppose further that during SFY 1997, the State reports 83,680 enrollee/months. The resulting budget estimate for ABD MEG in SFY 1997 is $535.68 X 83,680 = $44,825,702. Since the budget estimate is on a SFY, weighing adjustments will need to be completed to align the SFY budget estimates with the FFY. For example, using the ABD category and assuming that the State reports 87,504 enrollee/months for SFY 1998, for FFY 1997 the following adjustment will be made:

SFY 1997: $44,825,702 x .75 = $33,619,277
SFY 1998: $535.68 x 1.1070 x 87,504 x .25 = $12,972,419

FFY 1997 ABD MEG estimate = $46,591,696

The same calculation is repeated for the other six MEGs, and the seven MEG estimates and the FFY DSH estimate are added together to obtain a budget estimate for the year.

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A, Special Term and Condition #1(c). If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. No new limit is placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than six months after the end of an individual waiver year, the State will calculate annual expenditure targets for the completed year for each of the two components: benefits (using actual categorical eligibles) and DSH. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual claimed FFP for Medicaid. Using the below schedule as a guide, if the State exceeds these cumulative targets they shall submit a corrective action plan to HCFA for approval.

- Year 1 target spending limit	+8 percent
- Years 1 to 2 combined target spending limit	+6 percent
- Years 1 to 3 combined target spending limit	+4 percent
- Years 1 to 4 combined target spending limit	+2 percent
- Years 1 to 5 combined target spending limit	+0 percent

Attachment E

Access Standards

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of all covered services on an emergency basis, 24-hour-a-day, 7-day-a-week basis. At a minimum, unless Vermont can demonstrate otherwise, this shall include:

Primary Care Delivery Site:

a) Distance/Time: No more than 30 miles or 30 minutes for all enrollees from residence or place of employment.

b) Patient Load: A VHAP patient/primary care physician ratio to be determined by Vermont and approved by the HCFA project officer 30 days prior to implementation of the program.

c) Appointment/Waiting Times: Usual and customary practice not to exceed 30 days from date of a patient's request for routine and preventive office visits and 48 hours for urgent care.

d) Documentation/Tracking requirements:

+ Documentation - MCPs must have a system in place to document appointment scheduling times. Vermont must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey.

+ Tracking - MCPs must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

Specialty Care and Emergency Care: Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed 30 days for routine care

or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts.

Hospitals: Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater and for mental health and physical rehabilitative services where access is not to exceed 60 minutes. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to Vermont on the basis of community standards.

General Optometry Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards and documentation shall apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

Pharmacy Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.

Lab and X-Ray Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary": access that is equal to or greater than the currently existing practice in the fee-for-service system.

Attachment F

Outline for Operational Protocol

Vermont will be responsible for developing a detailed protocol describing the VHAP demonstration. The protocol is a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements

2. organization of managed care networks, and procedures for determining adequate managed care provider capacity by region

3. payment mechanism

4. benefit package

5. Medicaid eligibility process

6. marketing and outreach strategy (i.e., a) State-initiated marketing and recipient education activities; and (b) oversight of plan-initiated marketing activities)

7. enrollment process

8. eligibility simplification

9. quality assurance and utilization review system

10. administrative and management system

11. encounter data

12. federally qualified health centers

13. family planning services

14. pharmacy benefit for low income Medicare beneficiaries

15. financial reporting, including procedures for addressing insolvency issues

16. recipient grievance and appeal process

17. VHAP-Limited Fee-for-Service (Acute) Benefit, Uninsured

18. CRT Program

HCFA review and approval of the protocol will be consistent with the waivers granted and the proposal, as amended by the questions and answers submitted by the State.